

Exploring anti-asexual bias in a sample of Australian undergraduate psychology students

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Abstract

Research on attitudes towards asexual people is a relatively new focus within the discipline of psychology, and to date has not been a topic of focus in the Australian context. This study focused on Australian undergraduate psychology students, and their attitudes towards asexual people. The study recruited 231 participants from undergraduate psychology programs to complete an online survey assessing their attitudes towards asexual people, bias against single people, and gender ideologies. In addition, participants rated how comfortable and confident they felt about working with asexual people within mental health settings in the future. Participants who reported greater endorsement of traditional gender role ideology, and negative bias against singles, also reported greater levels of anti-asexual bias. Participants who hoped to pursue a career in psychology reported lower levels of anti-asexual bias and less negative attitudes toward single people, and reported moderate levels of both comfort in working with asexual people in the future, and capacity to provide safe care to asexual people in the future. Drawing on these findings, the paper concludes by discussing areas that require ongoing attention in the study of anti-asexual bias, and makes recommendations for the training of psychology students and clinicians.

Keywords: asexuality, attitudes, bias, psychology, singlism

Introduction

In the context of human sexuality, ‘asexuality’ is defined as experiencing no, or low levels of, sexual attraction (Bogaert, 2004; 2006; 2012; 2015; Brotto, Knudson, Inskip, Rhodes, & Erskine, 2010; Carrigan, 2011; Greaves, et al., 2017; Prause & Graham, 2007; Robbins, Low, & Query, 2016). This definition, however, serves as an umbrella term, containing within it significant heterogeneity (Brotto et al., 2010; Carrigan, 2011; Mollet, 2020; Zheng & Su, 2018). Asexual identities operate on a spectrum, which varies based on their degree of sexual attraction (Brotto & Yule, 2017; Mollet, 2020; Steelman & Hertlein, 2016). Identities such as grey-asexual and demisexual are included in the spectrum of asexuality, describing limited sexual attraction in specific circumstances or until certain criteria are met (Brotto & Yule, 2017; Carrigan, 2011; Dawson, McDonnell, & Scott, 2016). Bogaert (2004) identified 1.05% of individuals in a British national sample ($n > 18,000$) who were asexual. Several studies have since indicated asexuality to exist in approximately 0.40 – 1.05% of the general population across a range of countries (Aicken, Mercer, & Cassell, 2013; Bogaert, 2004; Greaves, et al., 2017; Poston & Baumle, 2010; Zheng & Su, 2018). Most asexual organisations (e.g., The Asexual Visibility and Education Network; AVEN, 2020) have adopted the view of asexuality as a sexual orientation, and this also reflects the current consensus among researchers (Bogaert, 2006; Chasin, 2011; Deutsch, 2018; Van Houdenhove, Enzlin, & Gijs, 2017).

A small but growing body of research summarized below has explored anti-asexual bias among the general population and in samples of college students. However, to date no such studies have been undertaken in the Australian context. This paper explores attitudes towards asexual people among a sample of Australian undergraduate psychology students. It seeks to

explore how gender ideologies, demographic variables, negative biases towards single people, and prior contact with asexual people relate to anti-asexual bias, and how such bias relates to perceived capacity to work with asexual people in a mental health setting (for those hoping to continue a career in psychology in the future). A focus on undergraduate psychology students, it is argued here, is important given that asexual people report higher levels of poor mental health due to discrimination (see literature below), and thus require inclusive mental health care. Focusing on undergraduate psychology students (as opposed to students more broadly) thus offers an important insight into the views of potential future clinicians who might provide support to asexual people.

Literature Review

Studies of mental wellbeing among sexual minorities have clearly established a link between marginalisation and mental health (Borgogna, McDermott, Aita & Kridel, 2019; Scherrer, 2008; Yule, Brotto, & Gorzalka, 2013). The normative assumption that all people should want to be part of an intimate relationship or to engage in sexual behaviour specifically negatively impacts upon asexual people (Borgogna et al., 2019; Deutsch, 2018; Yule et al., 2013). This is because asexuality challenges the normative assumption that sexual behaviour is an essential aspect of being human (Gupta, 2017). Gupta (2015) utilises the term ‘compulsory sexuality’ to describe these assumptions which marginalise the lives of asexual people.

In their study of mental health in self-identified asexual people, Yule, Brotto and Gorzalka (2013) found higher rates of anxiety, depression and suicidality among asexual people when compared to people of other sexual orientations. These findings were echoed in research by

Borgogna, McDermott, Aita, and Kridel (2019), who studied anxiety and depression across gender and sexual minorities. Their findings indicated demisexual and pansexual people had the highest levels of anxiety and depression, followed by asexual people. As MacNeela and Murphy (2015) aptly stated, “self identification [as asexual] places the individual in a threatening position that has to be managed” (p. 800). Management involves both navigation and resistance of threats to identity. Navigating threats such as denial narratives and microaggressions, for an asexual person, often involves highly restricted disclosure even among close friends and immediate family (MacNeela & Murphy, 2015; Robbins et al., 2016). The denial narratives, microaggressions, and pathologisation experienced by asexual people are evidence of the negative impact of compulsory sexuality (Chasin, 2015; Hoffarth et al., 2016). The impacts of denial narratives, microaggressions, and pathologisation upon the mental health of asexual people highlights the need for competent and knowledgeable mental health professionals who can provide inclusive care to asexual people.

Given the negative effects of normative assumptions on asexual people, it is important to be aware of attitudes toward asexual people. MacInnis and Hodson (2012) conducted two studies with heterosexual college students ($n = 148$), and heterosexual community members ($n = 101$) to assess anti-asexual bias. Participants in these studies resided in Canada and the United States. Both studies demonstrated that asexual people were rated least favourably on a thermometer measure when compared against heterosexual, bisexual, and homosexual groups. In addition, heterosexual people in this study reported greater discomfort on measures of future contact intentions with asexual people. Finally, MacInnis and Hodson found that anti-asexual attitudes were specifically related to higher levels of religious fundamentalism.

The initial findings of MacInnis and Hodson (2012) were echoed in the work of Hoffarth, Drolet, Hodson, & Hafer (2016), in their development of the Attitudes towards Asexuals (ATA) scale. The participants in this study (n = 339) were recruited from Mturk, with the majority of participants residing in the United States. Hoffarth et al. found that anti-asexual bias was higher in men, and strongly correlated with an endorsement of traditional gender norms and sexism. However, Hoffarth et al. noted that education, awareness, and intergroup contact with asexual people was associated with decreased anti-asexual bias.

Previous research on anti-asexual attitudes has also explored the role of singlism. Singlism is defined as negative attitudes toward single people (DePaulo & Morris, 2006). Asexual people may, of course, be part of a romantic relationship (Antonsen et al., 2020), and some asexual people may have past or present sexual experiences (Hille, Simmons & Sanders, 2020), however the normative assumption that romantic relationships equate with sexual relationships negatively impacts views on asexual people via compulsory sexuality (i.e., that either all asexual people are assumed to be single, or if they are in a romantic relationship, it is presumed to include sexual behaviour). Hoffarth et al., (2016) found a positive relationship between singlism and anti-asexual attitudes, such that those with more negative views about single people had more negative attitudes towards asexual people. Following Hoffarth et al., Thorpe and Arbeau (2020) found a relationship between singlism and anti-asexual attitudes, though acknowledged that the link between these two variables remains unclear, however is likely to constitute a specific form of discrimination. By contrast, MacInnis and Hodson (2012) did not find a relationship between singlism and anti-asexual attitudes.

Research Questions

Considering the above summarized research on anti-asexual bias, many asexual people are likely to experience significant marginalization which may contribute to poor mental health (Borgogna et al., 2019; Deutsch, 2018; Yule et al., 2013), and require inclusive clinical care. Bias towards asexual people has been documented amongst heterosexual people in community and college samples (Hoffarth et al., 2016; MacInnis & Hodson, 2012), though to date not in Australia. Thus, the study reported in this paper investigated Australian undergraduate psychology students' attitudes towards asexual people, including a focus on any differences between participants who hoped to continue with a career in psychology in the future, and those who did not or who were unsure. Specifically, this study sought to investigate the following questions:

1. Are there differences in demographic variables and measures of singlism and anti-asexual bias between participants who hoped to continue a career in psychology and those who did not?
2. What demographic variables are related to increased levels of anti-asexual bias?
3. How are both gender-role ideologies and negative bias against singles related to anti-asexual bias?
4. How does anti-asexual bias relate to intended future clinical contact with asexual people for participants who hoped to continue a career in psychology?

Based on previous findings, bias against asexual people was predicted to be higher among males, and those who report greater adherence to religion. Contact with asexual people was predicted to be associated with lower levels of anti-asexual bias. Anti-asexual bias was also predicted to be

positively associated with bias against singles, and negatively associated with endorsement of egalitarian gender role ideology. Anti-asexual bias was expected to be negatively correlated with perceived capacity to deliver mental health services in the future among participants who hoped to pursue a career in psychology.

Method

Participants

Inclusion criteria were that participants were aged 18 years old or older and currently enrolled in an undergraduate psychology course in Australia. The survey was open for 10 weeks (April – June 2020) and received a total of 273 responses. However, 42 responses were removed, leaving 231 responses in the final sample reported in this paper. Of the 42 removed responses, 11 only provided consent, 6 answered the demographic questions without continuing further, and 26 were removed due to extensive missing data on the measures. There were no significant differences between those who completed the entire survey and the 32 who were removed due to partial responses.

Procedure

Ethics approval was granted by the Flinders University Social and Behavioural Research Ethics Committee. The data were collected via an online survey. The survey was hosted on a research participant system for first year psychology students to obtain course credit. The survey was also posted to psychology student groups on social media for voluntary participation. Participants

were provided with information about the study and indicated their consent before proceeding to the questionnaire.

Measures

Participants answered demographic questions (See Table 1), and then proceeded to complete the following scales.

Attitudes towards gender roles scale. Participants completed the Attitudes Towards Gender Roles Scale (ATGR; Andrade, 2016), which is a 23-item measure consisting of two subscales; encompassing traditional (e.g., “the man should have the main responsibility for the family’s economic support”), and egalitarian (e.g., “Crying in front of other people is equally acceptable for men and women”) division of gender roles. Items were rated on a 5-point likert scale (1 = strongly agree – 5 = strongly disagree). Items representing egalitarian division of gender roles are reverse coded. The items are summed to obtain an overall score (range: 23 – 115) with a higher global score indicating greater positive attitudes toward gender role equality. Cronbach’s alphas indicated adequate internal consistency for each subscale: traditional division of gender roles ($\alpha = 0.79$), and egalitarian division of gender roles ($\alpha = 0.68$).

Negative stereotyping of singles measure. Participants completed a 30-item measure of negative beliefs against single people (Pignotti & Abell, 2009). Sample items include “People who do not marry can never truly be fulfilled”. Responses were recorded on a 5-point likert scale (1 = strongly disagree to 5 = strongly agree). Two items are reverse scored. The items are summed to obtain an overall score (range: 30 – 150) with higher scores indicating greater

negative biases against singles. Cronbach's alpha value ($\alpha = 0.95$) indicated significant internal consistency.

Attitudes towards asexuals scale. Participants were provided with the definition of asexuality (“a person who experiences very little or no sexual attraction”) and were asked to complete the attitudes towards asexuals (ATA) scale (Hoffarth et al., 2016). The ATA scale consists of 16-items assessing anti-asexual bias (e.g., “Asexuality is probably just a phase”) on a 5-point likert scale (1 = strongly disagree to 5 = strongly agree). Three items are reverse scored. The items were summed to obtain an overall score (range: 16 – 80) with higher scores reflecting greater anti-asexual bias. Cronbach's alpha value ($\alpha = 0.94$) indicated significant internal consistency.

Future clinical contact with asexual people. Participants were asked whether they were personally acquainted with a self-identified asexual person. Participants were then asked a series of questions regarding their thoughts about providing mental health care to asexual people in the future, focusing on three areas: comfort, confidence, and safety. Participants rated their comfort (e.g., “I would feel comfortable providing mental health services to someone who identified as asexual”), confidence (e.g., “I would feel confident in providing a mental health service to asexual adults in the future”), and capacity to provide safe care for asexual people (e.g., “I would be a safe person for others to talk to about their asexual identity”) on a 5-point Likert scale, ranging from 1 = strongly disagree to 5 = strongly agree. The scores for each were summed, with higher scores indicated higher levels of comfort (range: 4 - 20), confidence (range: 4 – 20), and safety (range: 6 – 30) about providing mental health care to asexual people in the future. Finally,

participants were asked if they hoped to pursue a career in psychology after completing their studies.

Analytic Approach

Upon closure of the survey, all data were exported into SPSS 26.0 and prepared for statistical analysis in the following ways. First, religious background was coded as either religious, non-religious, other, and prefer not to say. The religious category encompassed all participants who indicated a specific religious background, and the non-religious category included all non-religious, atheist, and agnostic participants. Second, all negatively scored items on the ATA, singlism, and ATGR scales were reverse scored, and composite scores were generated for each, along with the future clinical contact intention scales. Statistical tests were run to determine any differences between completers and non-completers. Incomplete responses were then removed from the data set.

To assess research question one, descriptive statistics were generated, and either Chi Square or One-Way ANOVAs were conducted on the entire sample. Univariate ANOVAs were conducted on the entire sample for research question two, controlling for differences in responses to the survey item asking participants if they hoped to pursue a career in psychology. Bivariate correlations were run with the entire sample to assess research question three and also research question four, however the latter correlations only included participants who indicated that they hoped to pursue a career in psychology in the future. Only statistically significant differences are reported below.

Results

Research question 1: Differences between participants based on intended career directions

Table 1 reports on the demographic variables collected. Of the 231 participants, the majority were aged between 18 and 24 years old ($n = 192$), were female, heterosexual, Caucasian, not religious, and had no prior contact with asexual people. In terms of their career plans, the greatest number ($n=94$, 40.69%) hoped to pursue a career in psychology, the next most common group ($n=86$, 37.23) were unsure whether they would pursue a career in psychology, and the least common response was those who indicated they would not pursue a career in psychology ($n=51$, 22.08%). Table 1 reports no significant demographic differences between those who hoped to pursue a career in psychology and those who were unsure or who said no.

[INSERT TABLE 1 ABOUT HERE]

Looking at two of the measures, however, there were significant differences between those who hoped to pursue a career in psychology and those who said no or were unsure, as outlined in Table 2. A one-way ANOVA yielded significant differences between the three groups on the singlism measure $F(2, 228) = 2.94, p = 0.05$. A post-hoc Tukey test showed significantly higher levels of singlism among participants who said they did not plan to pursue a career in psychology, as compared to those who said yes or unsure. Similarly, there were significant differences between the three groups on the attitudes towards asexuals scale, $F(2, 228) = 2.98, p = 0.05$. A post-hoc Tukey test showed significantly higher levels of anti-aexual bias among

participants who did not plan to pursue a career in psychology, as compared to those who said yes or unsure.

[INSERT TABLE 2 ABOUT HERE]

Research question 2: Demographic predictors of anti-asexual bias

Looking at the entire sample in relation to anti-asexual bias, differences in age and gender were not found to be statistically significant. However, anti-asexual bias was related to several other demographic variables. A Univariate ANOVA yielded significant differences between religious background $F(4, 226) = 2.74, p = 0.05$. A post-hoc Tukey test showed significantly higher levels of anti-asexual bias among participants who adhered to a religion as opposed to participants who were non-religious, atheist, or agnostic ($p < 0.05$). There were also significant differences in the degree of religious adherence $F(5, 225) = 3.44, p \leq 0.005$. A post-hoc Tukey test indicated significantly higher levels of anti-asexual bias among people who were somewhat religious when compared to those who were indicated being not at all religious ($p = 0.05$), and where religiosity was not applicable ($p = 0.05$). Regarding sexuality, significant differences were also found for anti-asexual bias $F(8, 222) = 3.45, p = 0.001$. Tukey post-hoc analyses indicated heterosexual participants reported greater levels of anti-asexual bias than bisexual participants ($p \leq 0.01$). Significant differences in ethnicity in relation to anti-asexual bias were also found $F(6, 224) = 5.16, p = 0.001$. Tukey post-hoc analyses indicated that participants from an Asian background reported higher levels of anti-asexual bias than both Caucasian participants ($p = 0.001$), and participants in the category 'other' ($p = 0.05$). Finally, a Univariate ANOVA yielded significant differences between whether or not participants had previous contact with an asexual

person, $F(2, 228) = 3.76, p = .02$. Participants who had previous contact with an asexual person reported lower levels of anti-asexual bias.

Research question 3: Relationships between gender ideology, singlism, and anti-asexual bias

On average, participants reported high levels of egalitarian gender role ideology ($M = 98.03, SD = 11.57$) as measured by the ATGR scale, and low levels of negative bias against singles ($M = 63.87, SD = 20.56$). Anti-asexual bias was found to have a strong negative correlation with the endorsement of egalitarian gender role ideologies ($r = -0.760, p = 0.001$). The less participants endorsed egalitarianism the more they endorsed anti-asexual bias. A strong positive correlation was found between anti-asexual bias and negative bias against singles ($r = 0.677, p = 0.001$). The more participants reported anti-asexual bias the more they reported negative attitudes toward single people. Egalitarian gender role beliefs and negative bias against singles was also found to have a strong negative relationship ($r = -0.610, p = 0.001$). The less participants endorsed egalitarianism the more they endorsed negative attitudes toward single people.

Research question 4: Relationships between anti-asexual bias and future clinical contact intentions

Participants who indicated that they wished to pursue a career in psychology reported moderate to high levels of comfort ($M = 18.34, SD = 2.05$), confidence ($M = 17.60, SD = 3.08$), and capacity to provide safe clinical care ($M = 20.83, SD = 3.52$) to asexual people in the future. Anti-asexual bias was found to have a moderate negative correlation with comfort ($r = -0.435, p$

= 0.001). The more anti-aseexual bias participants reported, the less comfortable they were with providing mental health care to asexual people in the future. A moderative negative relationship was also found between anti-aseexual bias and providing safe clinical care to asexual people in the future ($r = -0.308$, $p = 0.003$). The more anti-aseexual bias participants reported, the less they reported they were likely to provide safe mental health care to asexual people in the future. There was no correlation between anti-aseexual bias and confidence in future clinical contact with asexual people.

Discussion

Addressing research questions one and two, and different to Hoffarth et al. (2016), no significant differences were found in anti-aseexual bias on the basis of age or gender. This may be a result of the fact that most participants were women and were in the youngest age category. However, prior contact with an asexual person was found to be associated with lower levels of anti-aseexual bias, in line with the findings of Hoffarth and colleagues (2016). This echoes other research which has found that contact with specific groups of people can help to dispel stereotypes and increase awareness (Riggs & Bartholomaeus, 2016). The present study also found religion and degree of religiosity were related to greater anti-aseexual bias, echoing the findings of MacInnis and Hodson (2012). This may reflect the role of religion in shaping views about compulsory sexuality, specifically as it relates to procreation (i.e., that more conservative religious people may view sexual behaviour as central to romantic relationships, for the purpose of procreation). Adding to the existing literature, participants in the present study who identified as sexuality diverse demonstrated lower levels of anti-aseexual bias, an area that requires additional focus in future research, especially given that previous research suggests that asexual

people often experience marginalisation within sexuality and gender diverse communities (Mollet & Lackman, 2018).

Regarding research question three, anti-asexual bias was found to be positively associated with bias against singles and negatively with the endorsement of egalitarian gender role beliefs. These findings align with the results of Hoffarth and colleagues (2016), who also reported positive relationships between anti-asexual bias with singlism, the endorsement of traditional gender norms, and sexism. Finally in regard to research question four, the study found significant differences in terms of singlism and anti-asexual bias among participants depending on their future career plans, which related to perceived comfort and capacity to provide safe mental health care to asexual people in the future. This has implications for the training of psychology students, which is explored in more detail below.

Implications

The findings reported in this paper suggest implications in a number of areas. The first pertains to the training of psychology students. The findings suggest that participants who hoped to pursue a career in psychology reported lower levels of anti-asexual bias. Further research is needed, however, to explore how positive attitudes among future psychology graduates may be harnessed in the service of ensuring that such graduates are capable of providing care to asexual people. This may involve ensuring that teaching about sexuality diversity includes explicit teaching on asexual people, including sharing the voices of asexual people themselves. Research on trans people, for example, that has included trans people as educators for mental health students, reports more positive engagement and capacity (Hayward & Treharne, 2021). This

speaks to the finding in the present study that contact with asexual people was related to reduced anti-asexual bias. Including the voices of asexual people in psychology education (including as educators) may help to further reduce anti-asexual bias among psychology graduates.

Further in terms of psychology education, teaching about sexuality diversity, and asexuality in particular, must engage with myths that likely exist about asexual people, including that all asexual people are single. Given the relationship between singlism and anti-asexual bias found in the present study, unpacking normative assumptions about romantic relationships, including that they must always include sexual behaviour (i.e., compulsory sexuality), and conversely, challenging the assumption that all asexual people are single, may contribute to further reductions in anti-asexual bias and singlism, and greater competency in providing mental health care to asexual people in the future. This speaks to the lack of correlation found between confidence in such future work and anti-asexual bias. Participants who hoped to practice in the future might well have had more positive attitudes toward asexual people, but this does not automatically translate into future clinical confidence.

In terms of other implications, the findings reported in this paper suggest avenues for further research. As previous researchers have noted (e.g., Thorpe & Arbeau, 2020), the relationship between singlism and anti-asexual bias has not been clearly unpacked. Qualitative research will be essential to unpacking the intersections of singlism and anti-asexual bias, and to examining how these intersect with discourses of compulsory sexuality. Given that the latter is endemic to western societies (Gupta, 2015), it may be that compulsory sexuality as a framework shapes views toward both asexual people and single people. Research that explores this

possibility in detail can inform teaching to psychology undergraduates, so as to further challenge entrenched norms and stereotypes about asexual people.

Finally, within the field of lesbian, gay, bisexual, trans, intersex and queer psychology more broadly, a focus on asexuality is very much in its infancy (Ellis, Riggs & Peel, 2020). Concerted attention must be paid to the inclusion of asexual people not simply as part of an acronym, but as a group with specific mental health needs and experiences. As the findings reported in this paper would suggest, there are likely specific factors that shape anti-asexual bias, and these must be explored, including in terms of their intersections with other points of marginalisation, such as in regard to gender. This should include a focus not simply on how asexual people are viewed by non-asexual people in general, but also how asexual people are viewed specifically within gender and sexuality diverse communities, and the implications of community (dis)connection for the mental health of asexual people.

Limitations

Regarding limitations of this research, one area which was not assessed was whether the participants were aware of asexuality or not prior to taking the survey. This would have allowed for the assessment of whether prior knowledge had any effect on attitudes towards asexual people. This may have provided richer data on the differences among participants who were aware (vs. not aware) of asexuality and those who personally knew (vs. did not know) an asexual person. Furthermore, behavioural discrimination against asexual people was not assessed in this study, and may have potentially been a useful measure of external validity for the ATA scale.

In addition, asking participants how willing they might be to attend a workplace training or an educational lecture about asexuality may have also been helpful to assess potential behaviours which indicate a positive approach to working with asexual people in the future. An additional area of focus for future research would be to assess anti-asexual bias as it might be differentiated by target gender. In the present study the measure used only referred to a generic asexual person. Research on trans people, for example, has suggested that attitudes towards trans people are differentiated by gender (Wang-Jones et al., 2017). Future research would benefit from focusing more closely on how the gender of asexual people may differentially impact biases.

There are also limitations regarding the sample, as this research was conducted with a sample of university students. As mentioned by MacInnis and Hodson (2012), university students are often at the point of emerging into adulthood, where sexual activity and sexuality are highly valued by university students. Given that a majority of participants in this study were aged between 18 and 24 years old, this may be where attitudes toward asexual people may differ between university students and other groups. Further, university students may also be more liberal (MacInnis & Hodson, 2012), and therefore could potentially view sexual minorities more favourably than people in the community or within the field of healthcare.

Finally in terms of limitations, the present study accepted that those who hoped to pursue a career in psychology would indeed do so. Future research will benefit from assessing anti-

asexual bias among practicing psychologists, to identify if the patterns reported in the present study hold true for those who do in fact pursue a career in psychology.

Conclusion

The results reported in this paper are promising in that, at least in this cohort, potential future practitioners may perhaps be more willing to engage clinically with asexual people. However, it is also important to now assess the current status of anti-asexual bias in psychology more broadly, so that any current barriers and negative experiences of healthcare can be mitigated for asexual people. The wellbeing of asexual people in the community can also be promoted through this process of minimizing barriers in mental healthcare services. It may also be beneficial to explore anti-asexual bias and discrimination behaviours as well as positive pro-social behaviours of mental health practitioners with asexual people and the broader community. Doing so will help to provide insight into the broader societal picture, so as to understand the role of intergroup contact in minimising discrimination against asexual people, especially within the context of clinical health and mental health care. This is vital given that many asexual people experience mental health challenges due to discrimination, and may require clinical care that is inclusive and affirming.

Importantly, however, any focus on intergroup contact must ensure that the burden of challenging biases does not fall solely to asexual people. Certainly, this paper has argued for the importance of contact, including in psychology education. But contact in any form – in the community or in education – must be weighed against the mental health needs of asexual people,

many of whom may have a distrust of psychology in particular, given the historical and ongoing pathologisation of asexuality (Flanagan & Peters, 2020). As such, asexual people should be supported to be at the forefront of research and education that speaks to their experiences and needs, but at the same time all people should work to challenge myths and stereotypes about asexual people, including by engaging with the literature that has already been produced by and for asexual people (Chasin, 2011; 2015).

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Table 1. Participant demographics ($n=231$)

| Variable | <i>N</i> (%) | <i>p</i> |
|---------------------------|--------------|----------|
| Age Category | | |
| 18-24 | 192 (83.12) | .74 |
| 25-29 | 13 (5.63) | |
| 30-34 | 9 (3.90) | |
| 35-39 | 3 (1.30) | |
| 40-44 | 6 (2.60) | |
| 45-49 | 3 (1.30) | |
| 50-54 | 5 (2.16) | |
| Gender | | |
| Male | 60 (25.97) | .46 |
| Female | 169 (73.16) | |
| Non-binary | 2 (0.87) | |
| Sexual Orientation | | |
| Heterosexual | 182 (78.79) | .78 |
| Homosexual | 9 (3.90) | |
| Bisexual | 23 (9.96) | |
| Pansexual | 8 (3.46) | |
| Asexual | 3 (1.30) | |
| Prefer not to say | 3 (1.30) | |
| Another sexuality | 3 (1.30) | |
| Ethnicity | | |
| | | .41 |

| | | |
|----------------------|-------------|-----|
| Caucasian | 168 (72.73) | |
| Asian | 46 (19.91) | |
| Middle Eastern | 3 (1.30) | |
| Mixed Ethnicity | 7 (3.03) | |
| Other | 7 (3.03) | |
| Religious background | | .51 |
| Non-religious | 116 (50.22) | |
| Roman Catholic | 23 (9.96) | |
| Anglican | 4 (1.73) | |
| Other Christian | 24 (10.93) | |
| Muslim | 9 (3.90) | |
| Buddhist | 10 (4.33) | |
| Hinduism | 6 (2.60) | |
| Agnostic | 13 (5.63) | |
| Atheist | 10 (4.33) | |
| Preferred not to say | 5 (2.16) | |
| Another religion | 11 (4.76) | |
| Religiosity | | .97 |
| Not at all | 21 (9.09) | |
| Somewhat | 51(22.08) | |
| Quite a bit | 17 (7.36) | |
| A lot | 9 (3.90) | |
| Not Applicable | 133 (57.58) | |

| | | |
|-----------------------------------|-------------|-----|
| Prior Contact with Asexual People | | .71 |
| Yes | 55 (23.81) | |
| No | 176 (76.19) | |

Table 2. Measures differentiated by future psychology career intentions.

| Variable | <i>M, SD</i> | <i>p</i> |
|-----------------------|--------------|----------|
| Attitudes towards | | |
| gender roles scale | | |
| Yes | 98.88, 11.57 | .38 |
| No | 96.12, 11.72 | |
| Unsure | 98.23, 11.48 | |
| Negative stereotyping | | |
| of singles measures | | |
| Yes | 62.55, 21.99 | .05 |
| No | 69.94, 19.90 | |
| Unsure | 61.70, 18.72 | |
| Attitudes towards | | |
| asexuals scale | | |
| Yes | 26.39, 10.78 | .05 |
| No | 31.06, 10.34 | |
| Unsure | 27.72, 11.63 | |
